

Exhibit A

FALMOUTH**Invasive Cardiology**

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John C. Hostetter
M.D., F.A.C.C.
Bruce F. Levy
M.D., F.A.C.C.

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Thomas Sbarra
M.D., F.A.C.C., F.A.H.A.
David R. Urbach
M.D., F.A.C.C., F.A.H.A.

Vascular Surgery

James B. Knox**
M.D., F.A.C.S.

Nurse Practitioners

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Mark Sughrue
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Janet L. Thompson
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Richard B. Zelman*
M.D., F.A.C.C.

Interventional Radiology

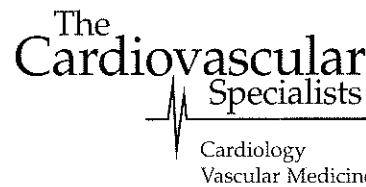
Philip J. Dombrowski*
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Matthew Tooker
RN, A.N.P.

**STATEMENT**

October 10, 2005

I have been asked to provide a further statement regarding the circumstances of Mr. Magee's hospitalization in December 2002 and the cardiovascular issues involved.

I believe my hospital records, evaluation review and treatment plans are self explanatory. In addition, my letter of April 18th, 2003 provided further opinion as to Mr. Magee's presentation.

Mr. Magee was hospitalized at Cape Cod Hospital on December 12th, 2002 after being transported by Life Flight from his fishing boat off shore with a diagnosis of chest discomfort. During that hospitalization laboratory review demonstrated no clear evidence of actual heart damage. His cardiovascular risk factors at that time, however, include a 5 pack per day smoking history, weight, hypertension and a family history of premature coronary disease. While his CPK blood test was elevated the Troponin blood tests were normal. His EKG was significantly abnormal. Because of his risk factor history, his clinical presentation, and the disparity between the CPK and Troponin, he underwent angiographic evaluation demonstrating moderate right coronary and severe circumflex and left anterior descending coronary disease with preserved systolic function.

Also significant on that admission was the occurrence of a gastrointestinal bleed with endoscopic evaluation suggesting a GI carcinoma with likely metastases.

As is reflected in his record, though interventional therapy was recommended and offered at Cape Cod Hospital at that time, the patient preferred to have his evaluation and treatment occur closer to home. The appropriate records were provided to the patient and he went back to New Jersey where his history and treatment were as documented.

The profound physical and emotional precipitant triggers for his acute coronary syndrome presentation are identified in the hospital record. It is quite evident with his cardiovascular risk factor profile that underlying coronary disease was present to a significant degree in Mr. Magee. The events clearly triggered his symptoms and the subsequent ischemic cascade. Both physical stress isometric type activity and emotional distress and all recognized triggers of the acute coronary syndrome. It would be impossible to ascribe a percentage of responsibility to either trigger. Suffice it to say that the circumstances were sufficient to provoke the symptom complex against the background of the identified risk factors and the subsequently identified baseline coronary disease.

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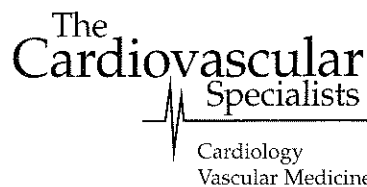
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There can be no doubt in my mind that those circumstances did provoke his clinical presentation. I do not believe that his gastrointestinal bleeding provoked the symptoms. The bleeding clearly occurred after his presentation to Cape Cod Hospital. As mentioned, the increased oxygen demand of his activity, emotional stress as noted, "shear" stress of the hyper-adrenergic state, tachycardia and accompanying hypertension all contributed to his presentation.

While having been a practicing physician since my Chief Residency at the University of Michigan in 1982 and a practicing clinical Cardiologist since 1988, after completion of my fellowship at the Harvard Medical School, New England Deaconess Medical Center site, and being board certified in Cardiovascular Disease, I would not portray myself as a "expert" in the field of Cardiovascular disorders. I have been thoroughly trained and feel that I practice cardiovascular disease assessment and management at a very high level of clinical expertise. I have suggested that it would be quite reasonable for Mr. Magee's legal counsel to obtain a true "expert opinion" from a clinical/academic physician at a tertiary level teaching program who specializes in acute coronary syndromes. I am confident that that person's assessment would corroborate and support my own opinions as articulated above.

I hope this statement has been helpful. If I may be of any further assistance, please contact me.

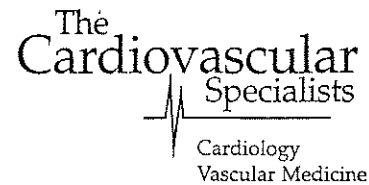
Lawrence S. McAuliffe, M.D., F.A.C.C.

LSM

djb

DD: 10/10/05

DT: 10/11/05



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April 18, 2003

Mr. Russell DuBois, AIC
Marine Safety Consultants
26 Water Street
Fairhaven, MA 02719-2962

Dear Mr. DuBois:

The following are the answers to the questions posed in your letter of April 12th.

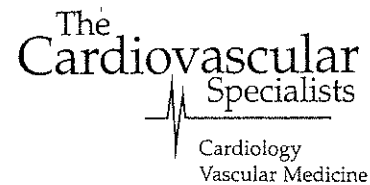
Coronary disease is a term to describe blockade of the coronary arteries. It is treated by a combination of medication, occasional non-invasive and invasive diagnostic imaging techniques, occasional catheter intervention either with balloon angioplasty and/or stent placement and occasionally with bypass surgery.

In my community palliative care is comfort measures only when no other definitive treatment or interventional therapies are available. Intuitively it is distinguished from curative care by the fact it is not curative but simply comfort only. I would utilize palliative care in the setting of end-stage heart disease when no other care could otherwise be provided.

I cannot answer the question regarding Mr. Magee's progression of coronary heart disease since I met him on only one occasion. I cannot answer the question of whether the progression could be arrested, cured or corrected.

It would be my impression that his discomfort on the boat was caused by coronary artery disease and that the effort expended doing his activity prompted an acute coronary syndrome – the inadequate delivery of blood and oxygen to the heart muscle. The possibility of musculoskeletal discomfort was raised because of the sharp nature of the discomfort. Cardiac chest discomfort can be sharp or dull in nature. Major blood vessel – aorta – abnormalities can be manifest with sharp discomfort as well.

Mr. Magee's course of treatment at Cape Cod Hospital was initially to provide stabilization; then to pursue evaluation and diagnosis of his chest discomfort syndrome. This demonstrated the presence of severe coronary disease. His course was complicated by GI bleeding and subsequent documentation of a malignant colon carcinoma. Due to the overwhelming nature of his medical problems and the fact that he was not in his home setting/community, further evaluation and treatment was deferred to his physicians at home.



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Mr. Russell DuBois
4/18/03
Page 2

An angiograph is either a non-invasive or invasive modality utilized to visualize a blood vessel. Percutaneous revascularization is the performance of balloon angioplasty, often followed by placement of a stent.

I cannot comment upon the connection between his GI problems and the coronary disease documented.

As mentioned above, at the time of discharge from Cape Cod Hospital his condition had been evaluated, identified and stabilized sufficiently to permit his care to be continued at another venue.

I have not seen Mr. Magee since his departure from the Cape so I cannot comment as to whether the bypass procedure improved his clinical status.

I hope these answers are helpful. If I may be of further assistance please contact me. If you have any conversation with Mr. Magee please extend my greetings and sincere hopes and wishes that he is doing well.

Sincerely,

Lawrence S. McAuliffe, M.D., F.A.C.C.

LSM:mle